MEDRX

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Notice of Independent Review Decision

DATE OF REVIEW: 2/20/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of TFESI Bilateral L4, L5.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Anesthesiology.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒Upheld (Agree)

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the TFESI Bilateral L4, L5.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female. On xx/xx/xxxx the patient sustained injury to her cervical spine, lumbar spine and abdomen. She was pulling, squatting down when she felt a sudden pull in her lower abdomen and spasm in her neck and lower back. The patient was seen at the emergency room on the date of injury. During an office visit on 09/13/2013 the patient was diagnosed as having a cervical and lumbar strain, and abdominal pain. She was provided naproxen. Office visit on 09/7/2013 notes the patients mechanism of injury –cervical strain, abdominal strain, lumbar strain with cervical paresthesias left upper extremity. 09/10/13 patient sees a chiropractor. 09/11/2013, the patient undergoes MRI abdomen, which shows

post-surgical changes anterior abdominal wall and diastasis hernia. 09/13/2013 functional capacity evaluation shows the patient is at sedentary physical demand level and her job is a medium physical demand level. 09/18/2013 MRI C-spine shows straightening of the normal cervical lordosis nonspecific, minor curvature, no compression fracture, spondylolisthesis or cervical disc herniation. 09/27/2013 office visit notes the patient experiencing a lot of neck pain and trouble with work restrictions. Cervical MRI is ordered with paresthesias down the left arm noted and pain in the buttocks. Pain medication is increased to include naproxen, Flexeril and Norco. The patient is referred to pain management and physical therapy. The patient attends physical therapy 10/03, 10/15, and 10/17/2013. On 10/19/2013, office visit MRI lumbar spine shows L4-5 four-millimeter central disc protrusion, L5-S1 one to the three-millimeter central disc protrusion with no neural impingement. MRI did not show pathology. Assessment is cervical abdominal muscular strain and lumbar strain. No radicular signs. states the patient does not need a neurosurgical consult and recommends a trial of physical therapy, diazepam, and naproxen. Patient attends therapy 10/22/2013. On 10/23/2013 at office visit MRI of the lumbar spine is reviewed and straight leg raise is positive on the right. The plan is to undergo epidural steroid injection L4-5 and start therapy. Patient attends physical therapy 12/2/2013, 12/9/2013, 12/11/2013, 12/18/2013, 12/27/2013, 12/30/2013, 01/3/2014, 01/8/2014, and 01/9/2014. Patients sees doctor, chiropractor Olivares 01/10/2014. Compensable diagnoses are abdominal pain, cervicalgia, cervical sprain/strain, lumbago, and lumbar sprain/strain. Patient is found to not be at MMI. 01/10/2014 the patient is seen in pain management. The patient had two prior hernia surgeries. refers her back to pain management and Ambien. 01/15/2014 office note noted steroid injections had not been approved. The plan is to submit for L4-5 epidural injection, send her for surgical evaluation, and continue a home exercise program. 02/08/2014 assessment is lumbar strain with radiculopathy. Neurosurgery consult is requested. 03/12/2014 notes workers' compensation has not approved epidurals. The patient reports an episode of bladder incontinence. An EMG is ordered. The plan is home therapy. 03/22/2014 office visit notes cervical and lumbar strain with lumbar radiculopathy. Patient attends therapy 03/26/2014, 03/31/2014, and 04/2/2014. Functional capacity evaluation on 03/30/2014 notes the patient at a light physical demand level and her job is a medium demand level. 04/03/2014, patient undergoes right L4 and L5 transforminal epidural steroid injection. 04/7/2014, the patient underwent EMG/nerve conduction studies, which read normal nerve conduction of the left and right lower extremity, and EMG of the right lower extremity and lumbar paraspinal muscles. F-wave study performed along bilateral nerve showed an absence of left superficial peroneal potential but it was absent on the unaffected limb. Therefore, clinical symptoms are uncertain. She received transforaminal epidural injections 04/17/2014 and two lumbar spine injections on 04/19/2014. Patient reports 30% pain relief from the first injection and 50% relief from the second. The patient continues to therapy. The patient also continues to see Chiropractor Olivares where she is not at MMI. 05/22/2014 the patient undergoes right L4-5 transforaminal epidural steroid injection and reports 75% pain relief at follow up on 06/11/2014. Function capacity evaluation on 05/30/2014 reports the patient is at medium physical demand level. 06/14/2014 office visit reports MRI of the cervical spine unremarkable. MRI dated 07/15/2014 shows bilateral L5 spondylosis, grade I anterior spondylolisthesis L5 and S1, associated disc degeneration and mild bilateral foraminal narrowing. No L5 exiting nerve root impingement in the supine postion; however, findings could be exacerbated with weight loading and flexion/extention and broad-based midline and left paracentral disc protrusion L4-5. At 08/13/2014 office visit

the patient reports pain and tightness in her trapezius region. On 09/13/2014 the patient undergoes C4, 5, 6 medial branch blocks and reports 75% relief from branch block on 09/23/2014. 10/22/2014 office visit with Chiropractor notes the patient is not at MMI. 10/23/2014 the patient undergoes C4, C5, C6 radiofrequency ablation.

12/9/2014 the patient sees. Patient reports increased low back pain and bilateral leg pain. The plan is to undergo bilateral L4-5 transforminal epidural steroid injection, refill tizanidine and hyrdocodone, and follow-up in a month.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Claimant had an L4-S1 facet injection without significant benefit and continued back pain after the procedure. Physician claims that the patient's relief was masked by the upper back pain the patient was experiencing. However, progress notes and physical exam demonstrate pain was from the lower back not upper back. Per ODG, there must be documented relief of 50-70% to justify these procedures. As the claimant did not have this relief after the first procedure it would be unnecessary to perform transforaminal ESI at these levels. Therefore, this request is non-certified.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

Official Disability Guidelines-Treatment for Workers' Compensation, Online Edition, 2013
Chapter Lower Back –Lumbar & Thoracic
Epidural steroid injections (ESIs), therapeutic
Recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Not recommended for spinal stenosis or for nonspecific low back pain. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, but ESIs have not been found to be as beneficial a treatment for the latter condition. According to SPORT, ESIs are associated with less improvement in spinal stenosis. (Radcliff, 2013)
Fluoroscopic guidance: Fluoroscopic guidance with use of contrast is recommended for all approaches as needle misplacement may be a cause of treatment failure. (Manchikanti, 1999) (Colorado, 2001) (ICSI, 2004) (Molloy, 2005) (Young, 2007)
An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal-Cochrane, 2009) Recent studies document a 629% increase in expenditures for ESIs, without demonstrated improvements in patient outcomes or disability rates. (Deyo, 2009) There is fair evidence that epidural steroid injection is moderately effective for short-term (but not long-term) symptom relief. (Chou, 2009) This RCT concluded that caudal epidural injections containing steroids demonstrated better and faster efficacy than placebo. (Sayegh, 2009) In this RCT there were no statistically significant differences between any of the three groups at any time points. This study had some limitations: only one type of steroid in one dose was tested; the approach used was caudal and transforaminal injections might provide superior results. (Weiner, 2012) Effects are short-term and minimal. At follow-up of up to 3 months, epidural steroids were associated with statistically significant reductions in mean leg pain and mean disability score, but neither of these short-term improvements reached the threshold for clinical significance. There were no significant differences in either leg pain or disability at 12 months follow-up. (Pinto, 2012) According to this systematic review, ESIs without the drug (epidural nonsteroid injections), often used as a placebo treatment, were as effective as ESIs and better than no epidural injections. (Bicket, 2013) This meta-analysis suggested that ESI did not improve back-specific disability more than a placebo or other procedure long-term (6 months), and did not significantly decrease the number of patients who underwent subsequent surgery. (Choi, 2013)
Criteria for the use of Epidural steroid injections:
Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.
(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
(4) Diagnostic Phase: At the time of initial use of an ESI (formally referred to as the “diagnostic phase” as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
(5) No more than two nerve root levels should be injected using transforaminal blocks.
(6) No more than one interlaminar level should be injected at one session.
(7) Therapeutic phase: If after the initial block/blocks are given (see “Diagnostic Phase” above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the “therapeutic phase.” Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)
(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
(9) Current research does not support a routine use of a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)
Chapter: Pain
Sedation: There is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. This is of particular concern in the cervical region. (Hodges 1999) Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. The general agent recommended is a benzodiazepine. (Trentman 2008) (Kim 2007) (Cuccuzzella 2006) While sedation is not recommended for facet injections (especially with opioids) because it may alter the anesthetic diagnostic response, sedation is not generally necessary for an ESI but is not contraindicated. As far as monitored anesthesia care (MAC) administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of post-op care. Supervision services provided by the operating physician are considered part of the surgical service provided.